and the same of th		7 7		
		..		
ACCS (C)		Link		
GORGEOT SAME UND	HEALTH SE	RVICE REQUEST	- Ca. 1	
Or	SOLICITUD DE	SERVICIO DE SALUD	1E-11	1
\cap	100			9-73-11
NAME (NOMBRE) LISO	nt chost		Request (Fecha de solicit	ng) Open C
ID # (Nº de Identificación)		DOB (Fachs de nacimiento) Unit (Unidad) <u>E 1 - 1 4</u>	2	
Site (Sitio)	he enecific) Naturaleza dal p	roblema o solicitud (sea espa	office): Ove on	ad conscion
with cust in Br	react a who	mesent time	LU LA IMIC C	oussaller
such Execut w	Hoch it ap	DOCUMENTO 12	1	u olte
of a baseball	Meed atter	tium a si	3013 OB (12)	22/016
0				
List Allergies (Numbre las alergias): I consent to be treated by Heaf	the Court Chaff for this court	flon described (Doym) or	ensentimiento para que la co	ndigión descrite sea
	ACUTATION OF THE PROPERTY OF T	me tollowing co-ceville	ILS ADDIV. ITTGGICAL MAN	
Dental visit (\$10.00), Medication check request (\$12.00). Medication	n 2 Pottile (medical cent	AL DEVOID (30, UL COULT).	LICATION TO TO LA LEGIS	u) and vvoigin
	. /	/) / ·		510
ierup Hard of	ump, Pt	Lell	Saul	(,02.0
to thousand	anichek	Amate Signat	ure and Date (Firms y fee	na del reciuso)
THIS FORM MUST BE HAND	ED DIRECTLY TO A NUI	ISE YOU	0	
ESTE FORMULARIO DEBE SER EN	TREGADO DIRECTAMENTE A	UNA ENFERMERA		
970		rite Below This Line		
5/11	34.114.11		4	· ·
00	211-		gh -	_
Received/Triage Date:	310 Time:	Signal Signal	ture. Date.	
Refer to:Provider	_NursingDental	Administrator		
Nurse Slaneture		Date/T	ime	
Nurse Signature:		7. 10.71		DE MENUELLE
	HEALTH CA	RE DOCUMENTATION	Nurse Pra	LOOKENOUS COLUMN
Response to Inmate:	You Sem	ala AIDI	() Correct Care	The state of the s
D A	de form	are Typi		40)
K. Dust w	Decellen	and Med	- war	
- COVIDIMAN	00 HID	IDAL IM	(E) Kiron	1/midOl
CA P MILLA			000	- 021
THOUT IS how	orter Was	A MONEOUER		
The state of	any a man	1		
altreday -	XHO		. 5	
01100 10	5100 IA	1 976	go	
ellipes () la	100 10	7	100	
	1			,
Nurse Signature:	T ' n /.	Date/Time	SCI OF	0/11
back	uma- a) la · Atch	DOB TO	Date
Inmate Name	BIN	ID#	200	
GOS-SCO14s 800	revised 7/1/00		NOTE: This is a 2-past form	-,-



HEALTH SERVICE REQUEST SOLICITUD DE SERVICIO DE SALUD

1614

AME (NOMBRE) Cilianand Scott	Date o	f Request (Fecha de so	(citud) 10-1-16
D	OB (Fecha de nacimiento		
# (N. de ideutilicación)	nlt R initian)		, i .
(B (SILIO)	lens a pateitud (sas espe	office): INE + C	ed iseurc
modered it is. Os you belowe o	MLI ITTS DOT	sale (-) 1 const gatter all	1.4
I have been been the total and the second	usa nous il) NEWO SOM	runur Clar
SAP. This is NOT SOMETHING MINO	r. I'll ound a	in I mave.	Ice of need
(Allender Steeler In steeler); A WA			
consent to be treated by Health Care Staff for the conditionated por el Personal de Asistenda Médics). I understand that the ental visit (\$10.00), Medication & Refills (medical, dental, neck request (\$12.00). Medical treatment will never be re-	psych) (\$5.00 each)	Pregnancy test (\$12	octors visit (\$12,00), .00) and Weight
	Inmate Stona	ture and Date (Firms y	echa del realuso)
HIS FORM MUST BE HANDED DIRECTLY TO A NURS	E		
STE FORMULARIO DEBE SER ENTREGADO DIRECTAMENTE A U	NA ENFERMERA		
	e Below This Line	4	
			The second secon
14		An:	
Received/Triage Date: 10-1-10 Time: _	O Signa	atura A Caigo	
	Administrator		
tions Clausteral	Date/	Time	
Vurse Signature			
and the second s	E DOCUMENTATIO	N	
	E DOCOMENTATIO		
Response to Inmate:		4.45	
as US ordered.	PM (M	store!	
	Ohren	4	fox.
a du			
	William	10	HISTORY IT
Remuned and	Melour	ed to T	WHENT
	Melou	ed to 7	WHANT
Remudedand		ed to 1	WHANT
Remindand Monor 165 PACE	SIM	60 1 50.	CORUMNIT
Remindand Monor 165 PACE	SIM		SWANT
Remudedand	SIM		WHAT I
Remindand Alono 160 PACE	SIM		ect Cara-Salltioner
Reminded and Offeners 165 PACE NO I DON'T NO	S IM		ect Care Solutions or
Remindand Alono 160 PACE	SIM		ect Care Solutioner Solutions Cocy
Concelland Offeners 165 PACE NO I DON'T NO	S IM BO 17 Date/Time	0	Core Solutions OCJ
Reminded and Offeners 165 PACE NO I DON'T NO	S IM		2 College Col

CCS-SCOfes 600

HEALTH SERVICE REQUEST SOLICITUD DE SERVICIO DE SALUD Date of Request (Fecha de solicitud NAME (NOMBRE) DOB (Fechs de nacimiento) ID # (Nº de identificación) Unit (Unided) Site (Sitio) Nature of Problem or Request (be specific) Naturaleza del problema o solicitud (sea especifico). MOTHIN GOO-BODING List Allergies (Nombre las alergias): I consent to be treated by Health Care Staff for the condition described (Doy mi consentimiento para que la condición descrita sea tretade por al Personal de Asistencia Médica). I understand that the following co-payments apply: Medical Doctors visit (\$12.00), Dental visit (\$10.00), Medication & Refills (medical, dental, psych) (\$5.00 each), Pregnancy test (\$12.00) and Weight check request (\$12.00). Medical treatment will never be refused regardless of my ability to pay. Inmate Signature and Date (Firms y (alpha del reciuso) THIS FORM MUST BE HANDED DIRECTLY TO A NURSE ESTE FORMULARIO DEBE SER ENTREGADO DIRECTAMENTE A UNA ENFERMERA Do Not Write Below This Line Time: 10 0 Signature: Received/Triage Date: Dental ___ Administrator Nursing Provider Date/Time Nurse Signature: HEALTH CARE DOCUMENTATION Response to Inmate: woon vehing Data/Time Nurse Signature: Date DOB ID# Inmate Name NOTE: This is a 2-past form revised 771/06